WHITE
MEMORIAL
MEDICAL CENTER

1720 Cesar E. Chavez Avenue
Los Angeles, California
90033 - 2467
213 268 5000

7 August 1995

Andrea Zach
Health Policy and Planning Division
Office of Statewide Health Planning and Development
1600 9th Street, Room 400
Sacramento, CA 95814

RE: OSHPD Risk Adjusted Mortality / Complication Study

Dear Ms. Zach:

White Memorial Medical Center welcomes the opportunity to participate in this study and believes that projects such as this contribute to improving the quality of care, and ultimately, the health status of our communities.

Upon reviewing our results, it was apparent that our data does not fit well within the two statistical models developed by OSHPD for the AMI and Lumbar Diskectomy study. OSHPD considers the analysis to be valid if the hospital's P-Value is less than 0.005. In these studies, our P-Values ranged from 0.189 to 0.529. This means the results of these studies for our hospital are consistent with chance and probably do not reflect a difference in the quality of care.

Based on the material sent to us by OSHPD, we have identified a number of patient records where our hospital's standard coding practices omitted those factors which would have changed the study's findings. Occasionally, these factors would have reduced a patient's predicted mortality or complication rate. More frequently, however, these omitted codings resulted in understated risk of mortality or complication.

Examples of coding challenges identified at our hospital include:

- Risk factors utilized in this study for severity adjustment (such as more specific AMI site, chronic medical problems, and obesity) are not routinely coded at our hospital.
- White Memorial Medical Center also does not routinely document o code certain prior medical conditions (for example, prior CVAs, CABGs, and/or pacemakers) not directly affecting the current admissions but which may increase patient risk according to this study.
- In many instances, we had difficulty determining demographic information (such as Hispanic versus Caucasian) which may have affected the predicted mortality / complication rate for our hospital in Model B which adjusted for socio-economic factors including race.

Also, OSHPD did not have access to some very important patient data:

- The status of the patient upon admission (i.e., consciousness, heart rate, existence of heartbeat) is not available. As an inner city hospital, we have patients who are found on the street unconscious or incoherent and brought by paramedic to the Emergency Department for treatment. We are not aware of the nature of their current illness nor the extent of any prior medical conditions (i.e., risk factors) for these patients.

- In our analysis of the Diskectomy studies, we identified patients that are listed as having complications when in actuality they were pre-existing conditions.

- For the AMI patients, the study did not have access to or take into account the existence of **"Do Not Resuscitate"** orders. **"Do Not Resuscitate"** orders are directives made by the patient or family regarding the level of medical intervention the hospital is to give the patient. Patients with **"Do Not Resuscitate"** orders are inherently at a higher risk of mortality.

- For the obstetrical patients, we have a high risk unit. The admission status of the patient could impact the outcome (i.e., age of mother, access to prenatal care, history of drug-abuse, etc.)

Thank you very much for the opportunity to review and respond to this study. If you require additional information or clarification, please contact us at (213) 268-5000, extension 1237.

Sincerely,

BETH D. ZACHARY
Chief Operating Officer

BRIAN JOHNSTON, MD
President of the Medical Staff